Over the Counter Medication Release 2024-2025

The staff of Campion Academy will not be able to administer any medications to your student without this form being **signed by someone with prescriptive authority**. Please have your health care provider mark each medication that the staff can administer as directed on the medication. ***FORM MUST BE SIGNED AND DATED AFTER 5/25/24***

Students Name _____ Date of Birth _____

__ All of the following medications can be administered

__I decline the opportunity for any medications to be given to the above-mentioned child while at Campion Academy or under the care of Campion Academy *(Please consider sunscreen and aloe vera at a minimum)*.

__ Acetaminophen*
__ Activated Charcoal *
__ Alcohol Swab*
__ ***Aloe Vera****
__ Antibiotic Ointment*
__ Antiseptic Wash*
__ Benadryl and generic (Diphenhydramine HCL)*
__ BioFreeze and generic*
__ Bug Spray*
__ Calcium Carbonate*
__ Cetirizine HCl*
__ Cough drops*
__ Glucose (Low blood sugar)*
__ Hydrocortisone cream*
__ Ibuprofen*
__ Imodium and generic*
__ Lip Clear plus Lysine
__ Instant Cold Spray* (tendon/ligament injuries)
__ Loratadine*
__ Lubricating eye drops
__ Melatonin*
__ Midol and generic for female students (Acetaminophen, caffeine, pyrilamine maleate)*
__ Mucinex and generic (Guaifenesin)
__ Multivitamin
__ Purified water (eye wash)*
__ Saline Nasal spray (Relief of dry nasal membranes)
__ Sudafed and generic (Phenylephrine HCI)
__ ***Sunscreen****
__ Tylenol Cold (daytime and nighttime) and generics (Acetaminophen, Dextromethorphan HBr, Phenylephrine HCl, Doxylamine succinate)*
__ Vitamin C
__ Zinc
__ Any prescription prescribed by MD/NP/PA that is prescribed for no more than 2 weeks
__ _____
__ _____

(Medications with a star (*) are supplied in limited amounts at school and on school trips)

Health Care Providers Signature: _____ Date _____
Health Care Providers Name and Phone Number: _____
Health Care Providers Address: _____
Parent/Guardian Signature: _____ Date _____

CONSENT FORM-PRESCRIPTION AND OTC MEDICATION ADMINISTRATION

(please complete one for EACH medication the student takes)

Name of child _____ Date of birth _____
Name of medicine _____
Purpose of medicine _____
Instructions (dosage, frequency, how many days) _____
Comments _____
Signature of physician _____ Date _____
Physician's Printed Name _____
Address _____ Phone _____
_____**I give permission** for the above named child to take the above medication at school as prescribed. I understand that the medication must be provided in a container appropriately labeled by the pharmacy or physician stating the name of the medication, the dosage, and the frequency
_____**I affirm that my child does not have any prescription medications**
Signature of Parent or Legal Guardian: _____ Date: _____
Parent/Guardian's Printed Name: _____

CONSENT FORM-PRESCRIPTION MEDICATION AND OTC ADMINISTRATION

Name of child_____ Date of birth_____
Name of medicine_____
Purpose of medicine_____
Instructions (dosage, frequency, how many days) _____
Comments_____
Signature of physician_____ Date_____
Physician's Printed Name_____
Address_____ Phone_____
_____**I give permission** for the above named child to take the above medication at school as prescribed. I understand that the medication must be provided in a container appropriately labeled by the pharmacy or physician stating the name of the medication, the dosage, and the frequency
Signature of Parent or Legal Guardian: _____ Date: _____
Parent/Guardian's Printed Name: _____

CONSENT FORM-PRESCRIPTION MEDICATION AND OTC ADMINISTRATION

Name of child_____ Date of birth_____
Name of medicine_____
Purpose of medicine_____
Instructions (dosage, frequency, how many days) _____
Comments_____
Signature of physician_____ Date_____
Physician's Printed Name_____
Address_____ Phone_____
_____**I give permission** for the above named child to take the above medication at school as prescribed. I understand that the medication must be provided in a container appropriately labeled by the pharmacy or physician stating the name of the medication, the dosage, and the frequency
Signature of Parent or Legal Guardian: _____ Date: _____
Parent/Guardian's Printed Name: _____

CONSENT FORM-PRESCRIPTION MEDICATION AND OTC ADMINISTRATION

Name of child_____ Date of birth_____
Name of medicine_____
Purpose of medicine_____
Instructions (dosage, frequency, how many days) _____
Comments_____
Signature of physician_____ Date_____
Physician's Printed Name_____
Address_____ Phone_____
_____**I give permission** for the above named child to take the above medication at school as prescribed. I understand that the medication must be provided in a container appropriately labeled by the pharmacy or physician stating the name of the medication, the dosage, and the frequency
Signature of Parent or Legal Guardian: _____ Date: _____
Parent/Guardian's Printed Name: _____